Agenda item 1.4

UNAIDS/PCB (57)/25.28.rev1

NGO REPORT

Community-led integrated HIV services: The future of a sustainable HIV response

16–18 December 2025 | Brasília, Brazil
UNAIDS Programme Coordinating Board
Issue date: 4 December 2025

Additional documents for this item:

Action required at this meeting—the Programme Coordinating Board is invited to:

- Take note of the report by the NGO representative;
- *Recognize* the indispensable role of communities as service providers, caregivers, advocates, monitors, and leaders, and recognizes that meaningful community leadership and well-resourced community-led HIV responses are fundamental to the realization of the Global AIDS Strategy, to the attainment of the 30–80–60 and 10–10–10 targets, and to ending AIDS as a public health threat;
- *Recall* all decision points from agenda item 1.4 of the 55th PCB;
- Noting with concern that reaching the goal of ending AIDS as a public health threat by 2030 is being negatively impacted by declining and unpredictable funding for community-led HIV responses, restrictions on civic space, regressions in gender equality and human rights as recognized under international human-rights law, and persistent stigma and discrimination, and other emerging challenges, *calls upon* Member States:
    a) Ensure that predictable, sustainable, and direct financing is directed to community-led organizations engaged in the HIV response, including through institutionalized social contracting and dedicated domestic budget lines, and ensure the full, timely, and increased funding mechanisms dedicated to community leadership and resilience, including within UNAIDS;
    b) Address structural, legal, and policy barriers to support equitable and human-right based, community-led integrated HIV services that leave no one behind including people living with and affected by HIV, particularly key[1] and priority populations, guided by community leadership and societal enablers to end HIV-related stigma, discrimination, and gender inequalities and health inequities;
    c) Develop, with the support of the Joint Programme, comprehensive and integrated health and social support service packages known to reduce HIV risk and vulnerabilities within national HIV and health plans, that link HIV testing, prevention including long-acting technologies, and treatment to the tailored needs of people living with and affected by HIV, particularly key and priority populations;
    d) Integrate and strengthen peer-led service delivery and community-led monitoring to improve service delivery quality, strengthen health systems, and enhance health equity including while encouraging innovative and digital approaches for monitoring and evidence-based decision-making in the national HIV response and broader health sector;
    e) Ensure that people living with and affected by HIV, particularly key and priority populations are actively engaged in the process of integration of the HIV response into related, coordinated multi-sectoral programmes;
    f) Strengthen systematic reporting through annual update of Global AIDS Monitoring report, in a transparent and disaggregated manner, on donor and domestic budget allocations supporting community-led responses and Human Rights programming, to monitor and inform progress toward the 30–80–60 and 10-10-10 targets, working collaboratively with Co-sponsors and the UNAIDS Secretariat;

Request the Joint Programme to:

a. Develop a plan through 2030 for the continuity of the support to and engagement of communities currently delivered by the UNAIDS Secretariat in the context of the further integration of UNAIDS into the broader UN system;
b. Reaffirm commitment to the meaningful involvement of people living with and affected by HIV, particularly key and priority populations in the implementation of the Global AIDS Strategy 2026–2031 and the UN General Assembly 2026 High Level Meeting on HIV/AIDS;
    a)

Cost implications for the decision: none

Table of Contents

Executive summary

1. The 2021 Political Declaration on ending AIDS and the Global AIDS Strategy 2021–2026 affirm the central role of community-led service delivery in achieving Sustainable Development Goal 3.3 target of ending HIV as a public health threat by 2030. In order to achieve that target, United Nations Member States have committed to have, by 2025:
   - 30% of testing and treatment services delivered by community-led organizations;
   - 80% of HIV prevention services for key populations and women delivered by community-, key population- and women-led organizations; and
   - 60% of programmes addressing societal enablers delivered by community-led organizations.

2. The Declaration and the Strategy further affirmed that by 2025, 90% of people living with, at risk of, or affected by HIV should have access to people-centred, context-specific integrated services for HIV and other communicable and non-communicable diseases, sexual and reproductive health and rights, mental health, and services that address gender-based violence.

3. As 2025 draws to a close, the 30–80–60 targets are not within reach at the current rate of progress. The prospect of achieving the 10–10–10 targets was unclear, according to the Global AIDS Update 2024, which described a slow expansion of community-led service delivery coupled with weak accountability frameworks.

4. Alongside political and structural reforms, the main deficits identified were weak harmonization, alignment and accountability. In addition, there was a lack of operational and country-owned monitoring frameworks that:
   - track community-led service delivery across facility-based and community spaces;
   - capture disaggregated investments in community-led responses (including networks/groups coordination, capacity strengthening, community-led monitoring and resilience support for addressing gender and human-rights barriers); and
   - ensure legal and policy reforms (e.g. scope-of-practice alignment, integration with national health systems and social contracting) that enable community-led models to function effectively.

5. Community-led integrated HIV services refer to the delivery of HIV prevention, testing, treatment and care together with the wider health and social services that communities identify as necessary for initiating and sustaining care. These services are delivered through platforms that are led, staffed, governed and accountable to communities themselves. Integration, as understood by communities, is inherently intersectional: it recognizes that people experience HIV risk and barriers to care through multiple, overlapping determinants, such as gender identity, sexuality, criminalization, poverty, violence and migration status, and therefore require services that respond to the whole person rather than a single issue.

6. This means delivering HIV care alongside gender-affirming services, sexual and reproductive health and rights, harm reduction, mental health and psychosocial support, legal aid, gender-based violence response, food and housing assistance, and

peer accompaniment. It amounts to more than the co-location of services: it is a holistic, person-centred, stigma-safe care "journey" that is grounded in trust, confidentiality and cultural safety, with peer leadership at every stage.

7. Despite their centrality to global commitments, community-led, integrated services face major barriers.

   - **Financing barriers**, including short-term or project-based funding, lack of core and flexible resources, limited domestic financing and challenges accessing direct funding from governments and donors.
   - **Capacity and systems gaps**, such as insufficient support for hiring and retaining staff, gaps in governance and organizational systems, limited accreditation pathways, and inadequate investment in peer and lay cadres.
   - **Restrictive legal and policy environments**, including criminalization, shrinking civic space, punitive regulations, and lack of scope-of-practice reforms that would allow community-led providers to legally deliver the services they already provide in practice.
   - **Integration approaches that risk eroding community leadership**, thereby compromising safe spaces, weakening confidentiality protections and undermining the specialized, population-specific models that communities rely on.

8. Despite these challenges, community-led, integrated services are opportunities to sustain an HIV response despite financial and political strain. This report identifies several priority actions.

   - Adopt a defined package of integrated services, linking HIV prevention, testing, treatment and care with sexual and reproductive health rights, trans-specific health care, harm reduction, gender-based violence response, mental health and psychosocial support, legal assistance, food and housing support, and peer navigation—delivered through community-led platforms across clinical and non-clinical settings.
   - Secure predictable, long-term, direct financing for community-led organizations, including through social contracting, covering indirect costs, professionalizing community staff and preserving earmarked funding where public systems are hostile or criminalizing.
   - Institutionalize community-led monitoring as an accountability mechanism, embedding feedback-to-action loops in national HIV plans, provider contracts and global reporting, with indicators tracking community-led coverage, financing flows and legal/policy reforms.
   - Align community-led models with national HIV and primary health care reforms, through formal recognition, joint planning mechanisms and inclusion in national strategies, benefit packages and investment cases, while safeguarding community leadership and independence.
   - Create enabling legal and policy environments, including decriminalization, protection of civic space, scope-of-practice reforms, and rapid-response mechanisms to detect and respond to restrictive measures.

9. The report reaffirms that *community-led integrated HIV services* are indispensable to achieving a sustainable and rights-based HIV response, particularly in resource-constrained, criminalized and precarious environments. These models do far more than

provide HIV testing, prevention and treatment: they combine HIV care with the broader health and social services that communities identify as essential to initiating and sustaining care. Community-led organizations offer trusted, stigma-safe spaces, reach people whom public systems cannot, reduce the indirect costs that prevent service uptake, and deliver culturally safe, person-centred support through peers who share lived experience.

10. This integrated approach strengthens continuity of care across clinical and non-clinical settings, embeds accountability and equity through community-led monitoring, and ensures that people experience a coherent, confidential and affirming care journey. The infrastructure enabling this work has been built over decades and cannot be replicated by government systems. Preserving and scaling up community-led integrated services is therefore not optional: it is foundational to achieving global targets, protecting health gains, and sustaining progress amidst shrinking resources and escalating threats to human rights and civic space.

Introduction and background

Purpose of this report

11. The NGO Delegation to the UNAIDS Programme Coordinating Board (PCB) annually presents a report on a topic of critical concern to civil society and communities affected by HIV to the PCB. The report includes recommended decision points.

12. The 2024 report, titled "Breaking the chain: supporting community leadership and human rights for a sustainable HIV response", identified tensions between efforts to meet the broader health and well-being needs of communities most affected by HIV, beyond HIV alone, and concerns about what "integrated" health service delivery might mean, particularly for those who provide and use community-led services.[i]

13. Building on those concerns, the 2025 report examines **community-led, integrated HIV services and their essential role in advancing people-centred, equitable, sustainable, and rights-based HIV responses.** The report draws on extensive consultations with community-led health networks, clinics and subject matter experts to analyse barriers and facilitators to expanding community-led, integrated HIV services.

Defining "community-led"

UNAIDS defines community-led organizations, groups and networks as “entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies and who have transparent mechanisms of accountability to their constituencies. Community-led organizations, groups, and networks are self-determining and autonomous, and not influenced by government, commercial, or donor agendas. Not all community-based organizations are community-led”.[ii]

14. Community-led service delivery has been the backbone of the global HIV response for more than four decades. From the earliest days of the pandemic, when many governments were slow to respond and health systems were ill-equipped or unwilling to serve people living with and affected by HIV, communities organized themselves to care for one another and demand that the global community do more to respond to this

global emergency. Community leadership generated breakthroughs in treatment access, pioneered peer-based service delivery models, catalysed the creation of transformative entities such as the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund), and ensured that the voices of people living with and affected by HIV remained at the centre of the response. The success of HIV response is inseparable from the strength of community-led action.

15. The model that resulted from the demands of communities—characterized by a “vertical” approach with dedicated HIV funding streams and standalone, HIV-centred service delivery platforms—has had an impact that was unimaginable in the earliest decades of the pandemic.[iii] [iv] However, there is growing discussion about the adequacy of this approach for meeting the broader and evolving health needs of people living with and affected by HIV, as well as for improving HIV-related outcomes and continuing progress toward epidemic control.[v]

16. The donor funding environment that gave rise to the "vertical" disease model also fostered the creation and growth of a vast network of community-led, community-based and key population-led organizations. These organizations emerged because mainstream health systems were failing to reach marginalized populations. Donor funding provided the resources to build alternative infrastructure. Decades of investment have created a sophisticated ecosystem of community-led clinics, peer networks, outreach programmes, safe spaces and advocacy platforms—led by and accountable to the communities they serve. This infrastructure is not incidental to the HIV response; it is foundational, and no government system can easily replicate it.

17. The importance of community-led service delivery is explicitly recognized in global HIV commitments. The 2021 United Nations Political Declaration on HIV/AIDS established the 30–80–60 targets, by which Member States committed that, by 2025, 30% of testing and treatment services would be delivered by community-led organizations; 80% of HIV prevention services for key populations and women would be delivered by community-, key populations- and women-led organizations; and 60% of programmes addressing societal enablers would be delivered by community-led organizations.[vi]

18. The 30–80–60 targets are embedded in the UNAIDS Global AIDS Strategy 2021–2026, which advocates for community-led service delivery as essential to achieving the Sustainable Development Goals (SDGs) and ending AIDS as a public health threat by 2030.[vii]

19. In an important recognition of the numerous social, political and legal factors that heighten risk of HIV acquisition and obstruct access to HIV prevention, treatment and care services, the Global AIDS Strategy 2021–2026 also articulates the 10-10-10 targets, which endeavour to ensure that by 2025 “less than 10% of countries have punitive legal and policy environments; less than 10% of people living with HIV and key populations experience stigma and discrimination; and less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence”.

20. However, these policy commitments and global ambitions are being tested by an unprecedented convergence of crises. The global HIV funding and programme implementation landscape is amid a rapid and deeply worrying transformation; one that

threatens to destabilize the current infrastructure of community systems and responses and, in turn, radically disrupt how people living with and affected by HIV approach their health and well-being.

21. For years, international donor funding for the global HIV response has either stagnated or declined, with several donors signalling their intentions to continue to reduce their official development assistance commitments in the years to come.[viii]

22. In addition to increasing uncertainty around the global HIV funding landscape, there are significant questions around *how* HIV programmes will be delivered moving forward, and by whom. One notable example is the recently adopted *America First Global Health Strategy*, which lays out a series of steps that could reshape the world's largest bilateral HIV programme, PEPFAR.[ix] This potentially includes dramatically reducing the role of non-governmental entities in implementing PEPFAR-supported programmes.

23. In response to the growing volatility in the global health funding landscape, the Global Fund has undertaken a "reprioritization" exercise to prepare for and respond to anticipated shortfalls in the fulfilment of donor pledges. In many countries, these reprioritization efforts have entailed the accelerated transition of Global Fund grant-supported activities to Ministries of Health, often without meaningful community engagement and at the expense of community priorities.[x]

24. These shifts have had profound effects on community-led HIV responses. Community-led organizations across the globe are grappling with sudden and substantial funding cuts, leading to reduced or eliminated services, staff reductions, facility closures and, in some cases, the closure of entire organizations.[xi] Organizations and services tailored to meeting the needs of key populations have been hit particularly hard.[xii]

25. Community-led organizations face additional threats. Across multiple regions, civic space is shrinking, in part through regulatory barriers that prevent or hinder nongovernmental organizations from registering, gaining access to bank accounts and legal operating. Anti-rights and anti-gender movements are gaining traction globally. These political and legal constraints compound the impact of the financial crisis, threatening to dismantle decades of community-built infrastructure precisely when it is most needed.[xiii]

26. Simultaneously, governments are having to rapidly assume the financial burden of transitioning former donor-supported programmes into national systems for health, while working to improve primary health care and achieve universal health coverage. In this context, questions around the long-term sustainability of "vertical" single disease-focused programmes have become critically important.

27. Moving ahead requires rejecting false choices. Governments and communities need not be in competition with one another. To respond to this moment of crisis and ensure the quest to end AIDS as a public health threat continues, community-led responses must continue to play a central and growing role in meeting the diverse needs of people living with and affected by HIV. Governments and communities must work in partnership to ensure the successful delivery of integrated services in the years ahead.

28. This report therefore examines community-led, integrated HIV services as a model that serves multiple urgent needs simultaneously: meeting the holistic health needs of people living with and affected by HIV; sustaining the community infrastructure that the HIV response depends upon: and offering governments a partnership strategy for achieving sustainability and universal health coverage goals. It will serve as a prerequisite for achieving people-centred, equitable, sustainable and rights-based HIV responses.

29. Integration, when communities lead it, means expanding the scope of what community-led organizations deliver while ensuring they have the resources, formal recognition and enabling legal environments to operate sustainably as permanent partners within national health systems.

30. The question is not whether the government or community should lead HIV services. The question is how to structure, resource and protect a complementary ecosystem in which both can thrive, with community-led organizations recognized and funded as essential, specialized service providers with distinct roles that government systems cannot fulfil. These questions are urgent. The decisions made now about how integration proceeds will determine whether decades of community-built capacity are preserved and expanded as a permanent feature of health systems, or whether it is dismantled in the misguided pursuit of government-only sustainability.

31. This report proposes that expanding and adequately resourcing community-led, integrated HIV services is the foundational prerequisite for achieving people-centred, equitable, sustainable and rights-based HIV responses.

Global frameworks on community-led integration and integrated service delivery

32. UNAIDS defines community-led HIV responses as: *"actions and strategies that seek to improve the health and human rights of their constituencies and that are specifically informed and implemented by and for communities themselves and the organizations, groups and networks that represent them".*[xiv]

33. The 2024 NGO Report to the PCB reaffirmed this definition, emphasizing that community-led AIDS responses are fundamental to sustaining progress and ensuring accountability to key populations and people living with HIV.[xv]

34. The concept of integrated health services, within the context of the HIV response, is defined by UNAIDS as: "*people-centred and context-specific integrated services for HIV and other communicable diseases, non-communicable diseases, sexual and reproductive health care and gender-based violence.*"[xvi] UNAIDS further affirms that social protection is integral to integration because it "*helps to address the multiple social determinants of HIV, including poverty, income inequality, gender inequalities, stigma and discrimination, and social exclusion,*"[xvii] and that effective integration requires strengthening "*health and social services, with communities fully integrated as essential partners in each and every aspect of the HIV response*."[xviii] Integrated services must also respond to the fact that "*dedicated HIV services do not always meet the broader health needs of people living with or affected by HIV*"[xix] and that "t*he holistic needs and human rights of people living with, at risk of and affected by HIV… remain insufficiently addressed because of inadequate integration of health services.*"[xx]

35. The concept of person-centred care, a core concept in delivering integrated services, is defined by WHO as:*"Person-centred care is an approach to care that consciously adopts the perspectives of individuals, caregivers, families and communities as participants in, and beneficiaries of, trusted health systems organized around the comprehensive needs of people rather than individual diseases, and respects social preferences"* .[xxi]

36. Based on the UNAIDS definition of community-led AIDS responses, the UNAIDS definition of integrated health services and the World Health Organization (WHO) definition of person-centred care described above, community-led integrated HIV service delivery can be defined as: "*the delivery of HIV prevention, testing, treatment and care in combination with other essential health and social services, provided through platforms that are led, governed and accountable to communities themselves".*

To what extent do global frameworks recognize and prioritize community-led integrated HIV services?

The 2021 UN Political Declaration on HIV and AIDS:

37. The 2021 Political Declaration set out, for the first time, explicit global targets for community-led service delivery. By 2025, governments committed to:
    - 30% of testing and treatment services delivered by community-led organizations;
    - 80% of HIV prevention services for key populations and women delivered by community-, key population- and women-led organizations; and
    - 60% of programmes addressing societal enablers delivered by community-led organizations.

38. In addition, the Declaration established a target that 90% of people living with, at risk of, and affected by HIV should have access to people-centred, context-specific integrated services for HIV and other communicable and non-communicable diseases, sexual and reproductive health and rights (SRHR) and mental health, and services to address gender-based violence by 2025.[xxii] These were landmark commitments, embedding community-led service delivery as an essential component of the HIV response at the highest political level.

39. UNAIDS has reported that those commitments are not within reach. The Global AIDS Update 2024 stated that "progress towards the 10–10–10 and the 30–80–60 targets is not within reach," citing slow implementation and persistent data gaps in country reporting.[xxiii] In practice, most national monitoring frameworks do not yet capture the proportion of services delivered by community-led organizations, leaving large parts of the commitment effectively untracked and underfunded. The NGO Report presented to the 55th PCB meeting in 2024 drew attention to this lack of accountability. It observed that, with less than two years until the 2025 deadline, there was no operational monitoring framework in place to track the 30–80–60 commitments. It urged the PCB to "retain and reinforce" these targets by mandating an accountability mechanism and linking it to an accelerated action agenda.[xxiv]

The Global AIDS Strategy 2021–2026

40. The Global AIDS Strategy 2021–2026 positions community-led service delivery as indispensable to achieving SDG target 3.3 and the goal of ending AIDS as a public health threat by 2030. It identifies communities not only as advocates and leaders, but as providers of services across the prevention, testing and treatment continuum.[xxv]

41. The Strategy also explicitly acknowledges that vertical HIV programmes cannot, on their own, meet the full health needs of people living with and affected by HIV. It recognizes that "dedicated HIV services do not always meet the broader health needs of people living with or affected by HIV" and calls for people-centred, integrated approaches.[xxvi]

42. The Strategy is structured around three strategic priorities: maximizing equitable access to services, breaking down societal and legal barriers, and fully resourcing and sustaining HIV responses. Community-led, integrated HIV services are aligned with each of these priorities, providing pathways to expand access, reduce stigma and promote sustainability.

Towards the Global AIDS Strategy 2026–2031

43. Work on the next Global AIDS Strategy, covering the period 2026–2031, is underway. The outline of the new Strategy presented during the 56th PCB meeting in June 2025 set out a renewed vision that is centred on equity, rights and sustainability and acknowledged that the world was not on track to meet the 2025 targets.[xxvii] Importantly, the the new Strategy champions community-led governance and recognizes that community-led responses are vital for achieving HIV outcomes and for reaching broader health and social justice goals.

44. More specifically, the initial recommendations in the Strategy outline called for:

    - Guaranteeing an enabling legal and policy environment, including protection of civic space, human rights and gender equality.
    - Expanding sustainable financing for community-led responses, including through social contracting, core and flexible funding, and domestic resource mobilization. Embedding communities in health systems as essential service providers, with formal recognition and resourcing of their role in integrated, people-centred HIV and health services.
    - Strengthening community-led monitoring, accountability and data systems, so that decision-making at all levels is shaped by evidence generated by communities.
    - Ensuring direct participation of communities in governance, planning and oversight of national HIV and health responses, including meaningful seats at the table in global and national bodies.

45. In parallel, the NGO Delegation conducted and presented the results of its own global survey. This survey gathered perspectives from civil society and community stakeholders on priorities for the next Strategy. Respondents ranked access to services as the highest priority and identified integration and community leadership as key pathways to achieve it. At the same time, they highlighted persistent barriers such as stigma, punitive laws and chronic under-financing.[xxviii] Both the Global AIDS Strategy

outline and the NGO Delegation's survey confirm that community-led and integrated service delivery must remain central to the next Global AIDS Strategy.

46. The draft Global AIDS Strategy 2026–2031 frames community-led and integrated service delivery as an operational imperative in the coming year. That entails placing community leadership at the heart of HIV and health systems strengthening; embedding communities as recognized service providers; ensuring sustainable financing and legal protections; and strengthening accountability through community-led monitoring and data collection.

Methodology

Data sources and sampling

47. This report uses a mixed-methods approach, including an in-depth desktop review, a targeted, a community-focused survey, and key informant interviews with community-led service delivery expert respondents. All data collection and analysis took place between June and September 2025.

48. A desktop review of published peer-reviewed and grey literature was conducted. It focused on community- and peer-led HIV service delivery, integrated HIV service delivery, and the intersection of these topics in community-led integrated HIV service delivery.

49. A quantitative and qualitative survey was co-designed with the NGO Delegation and community partners to gather key stakeholder perceptions about the definition of "community-led"; distinctions between community-led and community-based services; perceptions about the benefits of these approaches and about the barriers to their broader adoption; and recommendations for the UNAIDS PCB.

50. The survey was distributed by the NGO Delegation and its partners through key population networks and community platforms and received responses between 14 July and 4 September 2025. A total of 151 responses were gathered. A high-level demographic breakdown of the responses is included in Annex 3.

51. A total of 33 in-depth key informant interviews were conducted with members of organizations currently implementing community-led, integrated HIV service delivery organizations and community-led HIV service delivery experts (Annex 3). Interview guides for the key informant interviews were developed with input from the NGO Delegation and focused on gathering data on respondent perceptions about the impact of this model of care on client outcomes, including HIV prevention, treatment outcomes, and broader socioeconomic outcomes. Interviews were conducted in English, French and Spanish and were then analysed.

52. Six examples of innovative, community-led approaches for integrating efforts to meet the broader health and well-being needs of people living with and affected by HIV with HIV services were assessed to develop in-depth case studies (as shown throughout this document), with organizations nominated by the NGO Delegation. Case studies were selected to reflect examples of working with a diversity of communities, capturing regional differences, community realities, and in a range of geographic and socio-

political contexts. Semi-structured interviews with organizational representatives were conducted and analysed. Where feasible, interviews were complemented by document review, routine service data and user perspectives.

Analytical approach

53. Quantitative data from the survey tool were descriptively analysed by tabulation, including with disaggregation by population, region and other respondent characteristics.

54. The qualitative data obtained from interviews and open-ended survey responses were analysed thematically by the data collection team. Interviews were transcribed and translated into English and were reviewed to identify significant themes. Interview findings were synthesized into overarching thematic areas, with illustrative quotes extracted for inclusion in the final report.

Ethical considerations

55. All respondents were informed of the objectives of the data collection effort and provided explicit consent in writing (for those completing the survey instrument) and/or verbally (during interviews).

Limitations

56. It is important to note that the findings of this report and the research it is based upon are intended to be illustrative rather than comparative. They should be understood as part of a broader conversation on strengthening HIV responses through diverse, context-specific strategies. However, the insights gained through this research—and particularly those provided by the survey and key informants—while not generalizable, offer important evidence about what works for communities, and why centering their voices is essential for future service integration.

57. The capacity of community-led organizations to engage fully in the research underpinning this report was constrained by recent shifts in the global health funding environment. This challenge was particularly acute for organizations providing integrated services whose donor funding had been reduced, suspended or terminated. These constraints affected the depth and scope of engagement possible for the study.

58. This analysis was conducted in a condensed timeline, with in-depth engagements limited to a few focus groups of respondents and participants. While broader engagement would be valuable in future studies, the findings nonetheless provide rich insights and a strong foundation to inform ongoing dialogue and guide more extensive work on advancing community-led, integrated HIV services for a sustainable HIV response.

The role of community-led, integrated services in a sustainable, rights-based HIV response

59. UNAIDS advocates for integrated service delivery as a core strategy for ensuring people living with and affected by HIV receive “people-centred, outcomes-focused,

coordinated care across the life-course" by employing an appropriate mix of health- and non-health-based interventions.[xxix]

60. The Global AIDS Strategy 2021–2026 established the high-level target that, by 2025, "90% of people living with HIV and people at risk are linked to people-centred and context-specific integrated services for other communicable diseases, noncommunicable diseases, sexual health and gender-based violence, mental health, drug and substance use, and other services they need for their overall health and well-being".[xxx]

61. The effectiveness of integrated service delivery approaches and the likelihood of communities fully benefitting from them will depend on advancing models that appropriately reflect the needs and preferences of communities, their intersecting identities and the structural barriers they face. This includes providing the services most in demand; ensuring those services are delivered in a manner acceptable to the populations that need them; recognizing the need for an intersectional approach and leveraging the service delivery platforms that are best positioned to reach communities.

62. Drawing on the survey and key informant interviews, the next section describes the essential components of integrated HIV service delivery, including a description of the specific needs for populations most affected by HIV, based on the foundation of community ownership, leadership, and the intersectionality of identity and essential health-care needs.

The need for an intersectional approach to community-led integrated service delivery

63. Further, rapid progress in the global HIV response will only be achieved if integrated services reflect the diverse realities of the communities they intend to reach. UNAIDS and WHO emphasize that service delivery must address the social and structural determinants that interact to shape HIV vulnerability and health outcomes.[xxxi] [xxxii] This requires an explicit intersectional approach to integration, ensuring that services respond to people's lived experiences rather than to single-issue models of care.

64. Intersectionality is widely used in public health to explain how multiple social and structural determinants combine to shape HIV vulnerability, access to services and health outcomes.[xxxiii] Evidence shows that HIV risk and reduced access to care arise from intersecting influences, including criminalization, stigma, discrimination, gender inequality, poverty, disability and migration status.[xxxiv] [xxxv] Global reviews demonstrate that these intersecting factors are associated with lower uptake of HIV testing, delayed treatment initiation, reduced adherence to treatment and lower levels of viral suppression.[xxxvi]

65. The Global AIDS Strategy 2021–2016 emphasizes that reducing inequalities, including those captured in the 10–10–10 and 30–80–60 commitments, depends on addressing the overlapping structural determinants that shape trust, access and uptake of HIV and non-HIV services.[xxxvii]

66. The concept of intersectionality clarifies why communities experience multiple, simultaneous barriers across HIV, SRHR, mental health, harm reduction and gender-based violence services. These barriers include stigma in health settings, exposure to

violence, restrictive laws, policing practices and geographical or economic exclusion.[xxxviii] People facing intersecting oppression and barriers are more likely to delay testing, disengage from antiretroviral therapy (ART) or struggle to access prevention, treatment or psychosocial support.[xxxix] [xl]

67. Applying intersectionality to integrated HIV service delivery means recognizing that overlapping determinants influence where people seek care, whether they trust providers and the continuity of their engagement. For example, a transgender woman who sells sex and uses drugs may simultaneously face legal restrictions, stigma, violence and lack of gender-affirming services, which affect their access to HIV, SRHR, harm reduction and mental health care services.

Leadership and decision-making power across the delivery cycle

68. An intersectional approach requires not only integrated services, but also community leadership with real authority over how those services are designed, delivered and monitored. Community-led delivery is distinguished from generic community-based activity by the fact that it affords the affected community genuine authority and accountability across the full cycle of activities.

69. In practice, community representatives set priorities, approve service packages and hold sign-off on staffing models, budgets and operating procedures. Their authority and responsibilities are formalized in governance arrangements such as constitutions, terms of reference or decision matrices that specify which issues require escalation to boards or funders, and which sit within community remit.

70. In the survey and key informant interviews, community representatives also described taking the lead on pragmatic operational decisions that directly affect accessibility and acceptability. That includes setting operating hours, designing outreach strategies, adapting clinic flow and adjusting eligibility criteria in response to user feedback. For example, sex worker-led organizations may operate mobile outreach units in neighbourhoods where sex workers work, strategically delivering services during late afternoon or evening hours to maximize convenience and safety. Those decisions are embedded in service models and realized through signatures on plans and budgets, authorship of reports and representation in coordination fora.

71. To prevent tokenism, communities identified minimum governance thresholds and role-composition criteria. These typically include a super majority of governing body seats held by the relevant community, with most executive roles filled by community members and explicit delegation of decisions related to service scope, the hiring of community cadres and the handling of complaints. These safeguards are written into governing documents and recruitment policies, ensuring accountability, legitimacy and continuity.

Benefits and value-add of community-led, integrated delivery of HIV services

72. A growing body of literature demonstrates the potential for integrated service delivery approaches to improve HIV-related outcomes across the continuum of care. A 2021 systematic review of 114 studies, for example, found that integrated service delivery resulted in 67% higher uptake of HIV testing and counselling; 42% higher ART initiation

rates; 55% faster time to ART initiation; 68% better retention in care; and 19% higher viral suppression rates.[xli]

73. The vital role community-led models—including those led by key populations—have played in successfully delivering comprehensive integrated services is also increasingly recognized.[xlii] However, such models, though well-established, continue to be under-recognized and under-appreciated in broader discussions around integration.

74. Survey responses and key informant interviews highlighted that community-led, integrated services bring a set of distinctive benefits to people living with HIV and key populations. Communities described how these models build trust; ensure cultural safety and person-centred quality; improve uptake and continuity; reduce costs and time for clients; support efficiency and quality for health systems; and contribute to broader equity and accountability. Together, the findings show that community-led, integrated services are an essential component of a sustainable and rights-based HIV response.

75. **A foundation of trust**. Trust was repeatedly identified as the most important feature of community-led integrated services because it determines whether people will enter a service, disclose sensitive information and return for follow-up. Trust is established when people are supported and welcomed by peers, know that confidentiality will be respected, and recognize that services are designed around their real needs, realities and priorities—and that happens when services are led by—or meaningfully co-designed with—the people they are intended to benefit. For trans people, sex workers, people who use drugs, women, and young people, credible care involves peer support, respectful communication (including chosen names and pronouns), confidentiality, and predictable follow-up. Culturally competent staff who listen to and act on community guidance and patient preferences embody quality, safety and uptake. One of the basic mistakes many health-care providers make is to overestimate their knowledge about the communities they serve.

> *"The main thing is that the communities understand each other. So, you already feel like this is a trusted service, because there are experiences that are similar, particularly when it comes to discrimination and being marginalized and then you know, within those services, you can feel like you're not being judged by your background, your behaviour or your hardship… So, it's also about the trust, which is the most important thing with the community, so it's a safe space. You will feel like this is somewhere that I know that my identity will be protected, and that you are being cared for, like a person, rather than as a number."*
>
> - Community expert, Asia-Pacific

76. For many people living with HIV and many members of key populations, mainstream health facilities remain linked with experiences of stigma, discrimination and, often, criminalization. In contrast, community-led services were described as spaces where people can engage openly and feel protected. The presence of peers in clinical or support roles are an immediate sign of safety and trust, while the design of the services reduces the need for repeated disclosure in potentially stigmatizing settings, strengthening privacy and dignity.

77. These findings are supported by recent literature. The 2021 scoping review of community-led responses to HIV concluded that community-based testing significantly increased first-time testing compared to facility-based approaches.[xliii] A 2024 evaluation of a peer-led HIV and SRHR strategy observed higher engagement among young people when services were delivered by peers,[xliv] while a 2025 mixed-methods study in southern Africa found increased first-time testing and linkage to care in community-led models that were grounded in peer trust.[xlv]

78. **Cultural safety and person-centred quality**. Cultural safety and person-centredness were described as central to the effectiveness of community-led, integrated HIV services. This means that services reflect the identities, languages and lived realities of those who use them, and that people feel known, respected and safe. It also requires policy environments that are explicitly non-discriminatory and that protect trans and other criminalized communities from stigma, exclusion and punitive laws.

79. Community-led providers adapt services to the needs of specific populations. For transgender communities, this includes gender-affirming services and staff training on the unique needs of this population and respectful interactions. For sex workers, services integrate legal advice and gender-based violence responses. For people who use drugs, harm reduction such as overdose response and safer-use education is standard. Youth-led organizations ensure that governance structures, communication styles and service models are genuinely youth-driven.

80. For indigenous communities, cultural safety requires indigenous leadership and anti-colonial approaches that recognize how mainstream health systems have historically been sites of harm for indigenous peoples.[xlvi] Integration of indigenous models requires embedding traditional healing practices, Elder support, and ceremony alongside clinical services. Interview respondents emphasized that for many indigenous community members, indigenous-led organizations represent the only acceptable pathway to care due to historical traumas. Indigenous-led models of integrated service delivery, such as Ka Ni Kanichihk's Mino Pimatisiwin Sexual Wellness Lodge in Manitoba, demonstrate how culturally safe services can reduce barriers and expand access to care in a manner that ensures cultural safety.[xlvii]

81. **Improved uptake, continuity and outcomes**. The survey and interviews indicated that integration within community-led services reduces missed opportunities and strengthens continuity of care. By meeting multiple needs in one visit and providing stigma-free navigation, these services lower the chances that people will disengage from care. Respondents described models where testing, immediate initiation of treatment and psychosocial support were offered in sequence, with peers following up to maintain engagement. Survey findings showed that clients were more likely to remain in care when integrated care was available. Peer navigators and community health workers were described as essential to sustaining continuity. The 2021 scoping review also documented strong evidence of improved linkage to care, treatment adherence and retention in community-led models.[xlviii]

82. **Efficiency for people accessing services**. For clients, community-led integrated HIV services reduce the time and costs of accessing HIV care. Survey and interview respondents highlighted the convenience of one-stop services, where people can address multiple needs in a single visit. Survey findings showed that time saving, privacy protection and reduced indirect costs were major reasons why people preferred integrated models. By avoiding multiple visits to different facilities, clients save travel costs and time away from work or school.

83. **Efficiencies for the health system.** Community-led integration also supports efficiency and quality at the system level. Trained peer and lay cadres take on defined tasks under clinical supervision, freeing other cadres of staff while maintaining safety and standards. Coordinated services reduce duplication across vertical programmes and strengthen continuity through shared referral networks and record systems.

84. Community-led integrated HIV services deliver comprehensive packages by combining HIV services with SRHR, mental health and harm reduction services. These models were described as more effective than fragmented approaches at ensuring people navigate entire prevention or treatment pathways. The 2021 scoping review also reflected that community-led approaches contribute to structural gains such as improved viral load monitoring, reduced stockouts and stronger rights accountability.[xlix]

85. **Equity and accountability.** Community-led, integrated services also contribute to equity and accountability. They build stronger relationships between marginalized populations and health systems, provide mechanisms for client feedback and monitoring, and promote dignity and inclusion. Survey responses linked these models to improved health literacy, self-efficacy and social participation.

> *"[The Ministry of Health] understands* all the work we do behind the scenes, they un*derstand everything we can do, but we rarely sit at the decision-making table [...] The leadership is there. As far as the communities are concerned, the willingness to work is there. The work itself is being done, and sometimes better than in the health service, to the extent that we are allowed to do it. But decision-making? No, we're not there yet."*
>
> - Community expert, western and central Africa

86. Community-led monitoring was highlighted as a key accountability mechanism, ensuring that feedback translates into changes in practice. Respondents noted that these systems create shared responsibility between providers, communities and public-sector partners, helping to build systems that are more responsive and just. These perspectives are consistent with published evidence. A UNAIDS 2023 review of community-led monitoring noted improved responsiveness, client experience and policy reform when communities were empowered to collect and act on data.[l]

<u>Which services should be integrated into HIV care</u>

87. With respect to the non-HIV services most in demand, the research conducted for this report identified a non-exhaustive list of service areas which communities living with and affected by HIV would like to see provided alongside their HIV care: SRHR; transgender-specific health care; harm reduction; violence prevention and legal

support; and mental health and psychosocial support.

88. **Sexual and reproductive health and rights.** Integrating HIV and SRHR services has been found to be associated with improved rates of HIV testing, linkage to care and treatment adherence; likewise, such service integration is associated with increased access to and uptake of sexual and reproductive health services, as well as improved service quality.[li] [lii] [liii] In the survey done for this report, 41% of respondents reported accessing contraceptive services and family planning in the same space as HIV services, and 40% accessed pregnancy-related services and prenatal care.

89. Key informants emphasized that integrated SRHR and HIV services must offer a comprehensive, people-centred package. Minimum standards include contraception and family planning; pregnancy, breastfeeding and postnatal care; safe abortion where legal; prevention of vertical transmission; and access to inclusive, age-appropriate comprehensive sexuality education. Additional needs identified by communities include menopause-related support, human papilloma virus vaccination, cervical cancer prevention and screening, and information and care for female genital schistosomiasis.

90. SRHR services must be delivered in a manner that reflects the specific and intersectional needs of communities. For example, for young people (including adolescent girls and young women, and young key populations), services must be adolescent-friendly with strong consent and confidentiality safeguards, and protection from parental or spousal "gatekeeping". This is essential for all young people across key and priority populations, who face heightened risks of forced disclosure, stigma, family rejection and breaches of confidentiality.

91. Comprehensive sexuality education for young people must therefore be linked to differentiated, youth-centred SRHR and HIV services. Comprehensive sexuality education alone is insufficient when young people continue to face legal and structural barriers that limit their ability to access care safely and independently. Many young people, including those from key populations, are discouraged from seeking services because of restrictive age-of-consent requirements, discriminatory policies and concerns about confidentiality.

92. Alongside these shared needs, communities highlighted specific priorities: cervical cancer screening, human papilloma virus vaccination and female genital schistosomiasis-related care for women and girls; gender-affirming reproductive services for trans men and non-binary people; linkage of gender-affirming care to HIV/SRHR services for trans women; and SRHR organized to minimize policing risks and match sex workers' working hours.

93. Communities have demonstrated their strategic advantage in delivering integrated SRHR and HIV services to achieve improved outcomes.[liv] [lv] For example, the Diagonal Interventions to Fast-Forward Enhanced Reproductive Health (DIFFER) project implemented by the sex worker-led organization Ashodaya Samithi provided sex workers in Mysore, India, with a package of HIV and SRHR services.[lvi] Through this community-led approach to integration, the project was able to support dramatic increases in the uptake of both HIV and SRHR services: cervical cancer screening increased from 12% to 56%, and HIV testing increased from 26% to 73% within three months.[lvii]

94. **Trans-specific health care.** For transgender individuals, providing trans-specific health-care services can provide a vital pathway for accessing HIV services and improving HIV-related outcomes.[lviii] The landmark Longitudinal Cohort Study of Gender Affirmation and HIV-Related Health in Transgender and Gender Diverse Adults (LEGACY) study, which included 8,000 transgender, nonbinary, and gender-diverse patients in the United States, found that patients receiving gender-affirming hormone therapy had a 37% lower chance of acquiring HIV than those who were not receiving therapy; among those living with HIV, access to therapy was associated with a 44% higher chance of achieving viral suppression.[lix]

95. The Global AIDS Strategy 2021–2026 calls for 90% of transgender people to have "access to HIV services integrated with or linked to sexually transmitted infections, mental health, gender-affirming therapy, intimate partner violence programmes, and gender-based violence programmes that include post-exposure prophylaxis, emergency contraception and psychological first aid" by 2025.

96. Key informants emphasized that, at a minimum, trans-specific health care should include access to gender-affirming hormone therapy; gender-affirming surgeries; laser or electrolysis hair removal; post-surgical care; trauma-informed psychosocial support; and rapid access to post-exposure prophylaxis, sexually transmitted infection screening and treatment, and legal and psychosocial services for survivors of sexual and physical violence. Integrated trans-specific health care must also include youth-friendly adaptations, as adolescent trans people face parental-consent requirements, school-based stigma and confidentiality concerns that restrict their ability to access gender-affirming and HIV-related care.

97. Integrated services must ensure respect for chosen names and pronouns, and the use of accurate and affirming language when discussing bodies and anatomy. Communities stressed that these minimum standards can only be met when trans-specific health care is designed and delivered by trans-led providers. Lived experience was described as essential for creating safer environments, building trust, and ensuring that services reflect community norms, expectations and realities. A generic "key population-friendly" label does not achieve the same effect when leadership, staffing and decision-making authority are not held by trans people.

98. As with SRHR, communities have demonstrated their strategic advantage in designing and implementing integrated trans-specific health care and HIV services where, by meeting the broader health and well-being needs of transgender individuals through the provision of gender-affirming care and services, access to vital HIV services can be expanded and improved health outcomes can be achieved (see the Tangerine Clinic case study).

99. **Harm reduction.** Harm reduction is a core pillar of the HIV response and is widely recognized as an impactful and essential strategy for reducing HIV transmission and improving health outcomes. Sharing needles and other equipment exposes people who use drugs to HIV acquisition, as well as viral hepatitis, tissue infections, and systemic bacterial infections. Using disinhibiting drugs such as methamphetamine during sex, or "chemsex", is also associated with elevated risk of HIV acquisition.[lx]

100. People who use drugs often experience compounded health and social vulnerabilities, particularly when they are transgender, gay men and other men who have sex with men or are engaged in survival sex work. Chronic drug use is associated with intersecting forms of social marginalization, including criminalization, economic instability, homelessness and persistent exposure to traumatic interactions with law enforcement and health-care systems. By one estimate, 25% of people who inject drugs worldwide have recently experienced homelessness, 58% have been incarcerated, and 15% have recently engaged in sex work.[lxi]

101. At a minimum, HIV service delivery must incorporate the low threshold provision of sterile injecting equipment, naloxone, and overdose response. Given the high risks of criminal exposure and stigmatization, these services must guarantee confidentiality and protect against disclosures to patients' family members and community members or to law enforcement. For young people who use drugs, integration requires youth-friendly harm reduction, including confidential counselling, safe distribution of supplies, overdose support, and protection from punitive responses that criminalize or disclose drug use to parents. For gay men and other men who have sex with men and for trans people, integration must also address safer chemsex practices and offer non-judgemental counselling.

102. Given the risk of exposure to the legal system, and persistent criminalization and stigmatization, it is essential that harm reduction interventions are delivered by organizations of people who use drugs that are trusted, relevant, and considered safe by the community. People who use drugs-led providers can ensure that harm reduction messages resonate, while embedding services in local networks allows providers to adapt their outreach work to patterns of law enforcement activity, which facilitates safer access. Distinctive features include peer navigators with lived experience of drug use, recognition of drug user unions as legitimate service providers, and formal inclusion of harm reduction in national benefit packages.

103. Violence prevention and legal support. Violence that is tied to sex, gender identity and expression of societal gender norms is a risk factor for HIV acquisition and for disengagement from the care continuum for women, girls and key and priority populations.[lxii] [lxiii] By one estimate, nearly 30% of adolescent girls and young women (aged 15–24 years) have experienced gender-based violence in their lifetimes and 12% have experienced forced sexual debut.[lxiv] Gender-based violence increases HIV risk through several interconnected pathways, including exposure to HIV from perpetrators of violence, due to the relationship between violence, high-risk sexual practices, and substance use; and by systematically eroding individual resilience and autonomy over health decision-making among those regularly exposed to violence.[lxv] [lxvi]

104. Delivering gender-based violence-related care and trauma- and violence-informed health care is an essential component of HIV service delivery. Since violence is a structural barrier rooted in systemic inequalities, integration is especially important for populations who experience multiple layers of marginalization. At minimum, HIV services should integrate on-site access to post-exposure prophylaxis and emergency contraceptives, trauma-informed counselling and psychotherapy, legal support for safely reporting violence, and medical forensic examination services.

105. In the survey and key informant interviews, integration of legal and safety services was emphasized across populations. For sex workers, integration should includes violence prevention, rapid access to legal aid and safe reporting mechanisms. For adolescent girls and young women, it means safeguarding against coercion and gender-based violence. For young people in general, minimum standards include adolescent-friendly reporting channels, protection against retaliation by families or institutions, and integration of child protection and gender-based violence frameworks, where relevant. For people who use drugs, integration requires legal protections for harm reduction activities. For gay men and other men who have sex with men and trans people, it includes redress for harassment and for abuse in health and public settings.

106. Beyond access to medical services, violence prevention must be holistically integrated into all care and support protocols in care facilities. This includes screening for intimate partner violence before conducting index or contact tracing; medication safety counselling (for instance, considering long-acting options, discrete medication storage, and personalized safety plans); and strategies to protect the confidentiality and privacy of patient spaces. Additional evidence-supported interventions for reducing violence and victimization include skills development, community engagement and interventions that are focused on men and/or partners.[lxvii]

107. Beyond access to medical services, violence prevention must be holistically integrated into all care and support protocols in care facilities. That includes screening for intimate partner violence—particularly before conducting index or contact tracing—medication safety counselling (for instance, considering long-acting options, discrete medication storage and personalized safety plans), and strategies to protect the confidentiality and privacy of patient spaces.

108. Where age of consent laws are barriers to young people accessing care, alternative service delivery models such as peer counselling, anonymous helplines and community-based outreach should be implemented. For women living with HIV, services should include safeguards against coercion and gender-based violence, as well as protection from and redress for coercion, disrespect and abuse in services, including in relation to SRHR. Services should not exacerbate women's experiences of gender-based violence, for example requiring women to attend services with a partner.

109. **Mental health and psychosocial support.** Mental health profoundly shapes HIV outcomes, treatment adherence and quality of life, given that depression, anxiety, trauma and intimate partner violence are common among people living with and affected by HIV, particularly young people and key populations.[lxviii] [lxix] An analysis conducted by United for Global Mental Health found that integrating mental health services into HIV prevention programmes could catalyse a 10–17% acceleration in the reduction in HIV infection rates.[lxx] [lxxi] In the 2025 update to its guidelines for HIV service delivery, WHO strongly recommends that "mental health care for depression, anxiety and alcohol use disorders should be integrated with HIV services".[lxxii]

110. Key informants emphasized that integrated mental health and psychosocial support and HIV services must address the two-way relationship between mental health and HIV outcomes, as well as the effects of stigma, discrimination and criminalization on mental health and well-being. Evidence indicates that people experiencing mental health challenges are more likely to acquire HIV and people living with HIV are more likely to experience mental health challenges.

111. Minimum standards for integrated mental health and psychosocial support and HIV services identified by key informants include: screening and treatment for depression, anxiety and trauma-related conditions; substance use counselling and support; crisis intervention and suicide prevention; peer-led psychosocial support groups; and culturally appropriate therapeutic approaches. Additional needs identified by communities include support for neurodevelopmental conditions, eating disorders, grief and bereavement counselling, and interventions addressing internalized stigma.

112. It is vital that mental health and psychosocial support services be delivered in a manner that reflects the specific and intersectional needs of communities. For young people, including adolescent girls and young women and young key populations, services must incorporate developmentally appropriate approaches with strong safeguards against involuntary disclosure to parents or authorities. This is essential given that young key populations face compounded mental health risks from family rejection, school-based discrimination and identity-related stress.

113. Mental health support for all populations must also be trauma-informed, recognizing that many individuals have experienced violence, abuse or systemic oppression. To that end, peer support models are particularly valuable, since they provide safe spaces for shared experiences and reduce isolation.

Case study: Tangerine Clinic—Transgender-led integrated HIV services in Bangkok, Thailand

Tangerine Clinic, established in November 2015 at the Institute of HIV Research and Innovation in Bangkok, is a pioneering model of integrated HIV services for transgender individuals in Thailand. The clinic demonstrates how using community-led gender-affirming care as an entry point can significantly increase uptake of HIV services within the trans community, with clinic visits, repeat testing and pre-exposure prophylaxis (PrEP) use increasing significantly among transgender women who received hormone services.

The clinic's effectiveness stems from its fundamental reimagining of how health care serves transgender communities. Rather than treating HIV as the primary concern of the community, Tangerine recognized that for many transgender individuals, gender-affirming care is the most urgent health priority. By structuring services around this reality rather than top-down public health assumptions, Tangerine created "bundled services": clients returning for hormone level monitoring receive offers for HIV testing, which creates pathways to prevention and treatment that are free of the stigma that might be present when attending a general HIV clinic.

Between November 2015 and May 2023, Tangerine served 5,939 transgender women, of whom 91% received HIV testing and 1,414 were prescribed PrEP. Fully 98% of the transgender women who were receiving ART had viral suppression.[lxxiii] The clinic also conducts valuable implementation research, including the iFACT study, which showed no significant drug interactions between feminizing hormones and PrEP use, an important finding regarding a concern which had deterred many transgender women from using PrEP.[lxxiv]

Sustaining and scaling this model presents ongoing challenges due to funding volatility and

systemic barriers. Cuts to donor funding have forced the closure of office space and led to staff layoffs. However, the clinic remains open thanks to a combination of National Health Security Office reimbursements, client payments and pharmaceutical company clinical trial funding.

Beyond financial sustainability, the clinic faces the challenge of creating career pathways for transgender staff rather than limiting them to honoraria-based or short-term positions. While Tangerine successfully trains peer researchers, evaluators and service providers, these individuals often move to universities or other organizations that offer permanent employment with benefits—a success in individual terms, but also a sign that stable structures are not being built. The clinic has worked strategically to address these barriers through policy advocacy. It successfully pushed for Thailand's National Health Security Office to include gender-affirming care in the Universal Health Coverage programme and for Ministry of Public Health regulations that allow trained lay providers to provide certain clinical services.

Case study: Youth leadership in Africa (READY+)

The READY+ programme is a powerful example of the role of youth leadership in addressing the HIV epidemic among adolescents in eastern and southern Africa, where assessments have revealed that young people acquire HIV at a rate three times higher than other demographics.

Launched with the support of Frontline AIDS, this initiative has empowered over 27 000 adolescents and young people living with HIV across six countries: Angola, Eswatini, Malawi, Mozambique, Zambia and Zimbabwe. The programme has focused on increasing access to holistic care and support, promoting not only HIV services, but also SRHR, mental health and youth empowerment to foster resilience, build youth power and improve health outcomes. Additionally, the programme has focused on many of the challenges faced by youth, such as disclosure of HIV status by their parents, stigmatization of young pregnant people living with HIV, cultures of shame and discrimination, and difficulties participating in advocacy spaces.

READY+ addressed these challenges along several pathways. First, the programme created safe spaces within the clinics, staffed by peer educators who received extensive training. In those spaces, young people receive medical information and support with retention and treatment. By collaborating with health-care workers, READY+ was able to promote youth-friendly services at facilities by training clinical staff on the unique needs of young people living with HIV. \

More broadly, the programme sought to create a supportive community for young people by engaging with caregivers, parents, teachers and faith leaders to reduce HIV stigma and prepare the caregivers to provide accurate information to the youth they support. Finally, the programme supported young people to be activists. They gathered information about the challenges experienced at clinics, participated in open dialogues within communities, and engaged directly in platforms with decision-makers and in technical working groups with governments and donors.

According to READY+, the programme helped achieve viral suppression levels of 97% and the near elimination of vertical transmission among enrolled young mothers in the United Republic of Tanzania, for example. While the programme has faced challenges, engaging with governments has proved to be an essential part of the program. Partners in the public health-care system are invited to participate in trainings, which has allowed the Government to scale the trainings to regions not reached by the READY+ programme. In addition, strengthening relationships with governments is considered an important strategy for ensuring long-term funding sustainability.

Case study: 9 Circles Community Health Center—A coalition model for integrated HIV care among indigenous communities in Manitoba, Canada

Even in contexts where health systems and services are primarily financed and managed by national and local governments, community-based and community-led organizations play a central role in delivering services. An example is the Nine Circles Community Health Center and the network of Indigenous-led partner organizations it works with across Manitoba, Canada.

The mission of Nine Circles is “to provide low barrier, culturally safe prevention services, comprehensive care, advocacy and education for key populations susceptible to, or living with, HIV and other sexually transmitted and blood-borne infections, while working to eliminate stigma and advocate for health equities". To advance this mission, the Nine Circles model is guided by nine core values: belonging, client-centred, safety, integrated, culturally safe, developed in partnership, outcome-oriented, excellent standards of care, and meeting resiliency with resources.

Nine Circles now provides primary care with family doctors acting as HIV specialists, alongside mental health therapists, occupational therapists, dietitians, social workers and harm reduction programmes. The organization served 1,563 clients across over 11,000 appointments in 2024–2025.

While Nine Circles is not Indigenous-led, it predominantly serves Indigenous populations, who bear a disproportionate burden of HIV in Manitoba. Central to its model is working in close, accountable partnership with indigenous-led organizations in the province, including Aboriginal Health and Wellness Centre and Ka Ni Kanichihk Mino Pimatisiwin Sexual Wellness Lodge. Largely funded through the Winnipeg Regional Health Authority, Nine Circles has strategically maintained independence from direct provincial control to preserve its ability to respond to community needs.

At the heart of Nine Circles' innovation is the Manitoba HIV-STBBI Collective Impact Network (CINetwork), a coalition of actors working on HIV and sexually transmitted and blood-borne infections across Manitoba, with Nine Circles serving as the coalition's “backbone”, coordinating organization. The CINetwork is structured to require collaboration and coordination between actors that traditionally work separately—including hospitals, primary care providers, government health authorities, research entities and community-led and community-based organizations.

The CINetwork has developed a unique power dynamic, with community organizations controlling funding which hospitals and government health entities need. Traditional power holders must therefore negotiate with Nine Circles and communities rather than dictate terms. In 2024–2025, the CINetwork reached 565 individuals across 15 activities, with 95%of them reporting increased knowledge of evidence-based HIV prevention and 97% implementing stigma-reducing practices.

What is standing in the way of community-led, integrated services?

Sustainable HIV responses require funding mechanisms that consistently resource community organizations with sufficient, flexible, and empowering support

114. Successfully integrating additional health and social services into community-led infrastructure fundamentally requires consistent and sufficient funding streams. Findings from the survey and from interviews point to three primary routes: (i) public contracts or reimbursement for defined services through national purchasers; (ii) direct, flexible, multi-year funding to community-led organizations; and (iii) budget recognition and payrolls for peer and lay cadres so frontline roles can be sustained even when external grants end.

115. Health financing landscapes differ across regions and geopolitical contexts. In some settings, such as western and central Africa, HIV responses remain heavily dependent on donor funding, whereas in parts of Latin America, social contracting with community organizations is more established. A similar situation is observed in Asia-Pacific as well. Besides those established routes, innovative financing models such as debt-to-health swaps and debt-transfer mechanisms have been proposed as ways to diversify resources and strengthen domestic health financing. Those mechanisms can increase overall public funding for health but they do not necessarily generate direct, flexible resources for community-led organizations or enable them to be contracted as service providers.

116. Community-led organizations (CLOs) already face significant financial challenges. They are often funded through inconsistent, small and short-term grants and contracts. In addition to being a significant barrier to continuity of quality service delivery, such funding streams are highly dependent on donor priorities.

> *"Women-led responses have been chronically, disproportionately and profoundly underinvested in. That's not just in the HIV response, that's across the board. It's a very dangerous time for women's networks."*
>
> - Community expert, North America

117. International organizations which fund CLOs for service delivery often do so by reimbursing for services provided, but without funding core operating expenses and indirect costs. As a result, CLOs face challenges hiring staff, diversifying resource mobilization strategies, and developing institutional capacity. Those gaps make it difficult for CLOs to build sustainable, long-term organizational resilience, leaving them vulnerable to the withdrawal of donor funding.

> *"The Global Fund is training peer educators, but it's not sustainable training for the organization. Is the Global Fund able to finance the organizations' staff, for example, and say, 'I can train the staff in monitoring and evaluation so that even if the Global Fund leaves, this organization will have a monitoring and evaluation plan and will have a monitoring and evaluation officer who is strong in accounting.'"*
>
> - Community expert, Western and central Africa

118. As bilateral aid from the major donors shrinks, multilateral organizations will necessarily take on a larger role in funding CLOs, notwithstanding their own reliance on foreign government funding. However, these institutions are not all well-positioned to effectively fund CLOs: the Global Fund, for instance, typically channels its funding

through governments. Direct funding pathways to CLOs can bridge this gap but must be accompanied by strengthened commitments to transparency and accountability.

119. The global economy continues to grow, which suggests that resources exist in the system to support community infrastructure. However, a trend towards isolationism, nativism and militarization also poses a threat to international development. Additionally, high levels of debt are a significant barrier to domestic health financing in many countries. Nonetheless, as a proportion of the global HIV response, community-focused programmes are not expensive.

> *"Beneficiaries no longer have access to PEPFAR [...and] the organizations are closing down. And what will happen as a result is that there will be new HIV-related deaths, there will be new cases of HIV infection. There will be an increase in STIs. In short, we are going to pay for everything we have spent 30 years building, which is in danger of being lost in such a short time, and donors will also no longer include the issue of key populations in their strategy, it will no longer be a priority, and that will be the end of everything we have done, just when we are in the home stretch, as they say, but unfortunately, everything is being ruined, and that's a shame."*
>
> - Community expert, western and central Africa

120. Creating structures for domestic, public resources to support CLOs with service delivery is one strategy to finance sustainably supporting community-led service delivery. However, that approach involves several barriers and risks.

121. In general, governments that criminalize key, priority and other marginalized populations cannot be the funders of community-led service delivery for those groups, not least because legal pathways for social contracting them are not in place. Decriminalization is an urgent, fundamental imperative—but it takes time to achieve. Sustained funding from nongovernmental sources for these organizations is therefore non-negotiable. In contexts where donors transition funding and ownership of health programmes to governments, it is essential to sustain longer-term donor funding specifically for community-led service delivery.

> *"It's just not possible to integrate key population services entirely into government health-care settings without also decriminalizing laws that criminalize key populations."*
>
> - Community expert, North America

122. In contexts where social contracting exists, care must be taken to ensure that public funding of service delivery by CLOs does not unintentionally result in increased costs for clients. To be eligible for government funding or reimbursement, CLOs may be required to align with government payment structures, which can distort cost structures and service delivery models and ultimately detract from the quality of care provided to clients.

123. Efforts to integrate additional services into community-led infrastructure must be accompanied by funding specifically for this transition. With CLOs already financially strained, adding additional labour without commensurate funding risks undermining

service delivery, organizational health, and staff well-being. In cases where CLOs provide more integrated service delivery without being formally recognized by the public health-care system, these organizations face challenges procuring essential medicines, tools and other commodities.

Targeted capacity strengthening is essential to equip community-led organizations with the skills, systems and resources needed to lead and deliver integrated HIV services effectively

> *"There is a need for training, because today HIV is no longer the activism it used to be, when it was necessary to chant slogans at conferences. Today, people need to know there are IT tools, you need to know how to conduct a survey, carry out studies, generate data, and advocate based on data. And for that, you need to be trained. [...] It's not just because we're the people [living with and affected by HIV] that we can automatically do it better. We need training, we need people to speak up, we need charismatic leaders, we need leaders who will champion the cause of these people in decision-making bodies such as the CCM [country coordinating mechanism], the Global Fund and others."*
>
> - Community expert, western and central Africa

124. Empowering CLOs to deliver a broader set of HIV and non-HIV related services will require sustained training, capacity building and support. Community-led delivery depends on having a formally contracted, salaried, competent workforce that is drawn from relevant communities. Core cadres include peer supporters, lay counsellors, outreach workers, navigators and case managers. Their scope of practice tends be explicitly defined: for instance, HIV self-testing support, finger-prick testing, linkage to ART or PrEP, adherence support, harm-reduction counselling and overdose response.

125. A lack of sustainable funding streams often leaves CLOs heavily reliant on community volunteers and staff who do not have specialized medical training. CLOs must be supported to hire technical staff, adequately compensate their community staff, and professionalize their human resources infrastructure. This capacity building may also be achieved through grants or programmes to train community members in the more technical aspects of service provision.

126. Many CLOs also lack sufficient physical infrastructure to expand service delivery, particularly when operating in rural areas. Adding additional types of care to existing clinics and community spaces can attract a broader and larger clientele, which could lead to overcrowding and longer wait times.

127. Training, supportive partnerships, and resources are essential for preventing burnout of CLO staff, many of whom are already exhausted by their current scope of work. Conversely, integrating community-led services into public clinics can also mean adding workloads to overburdened health-care systems, many of which also face financial crises due to cuts in donor funding.

128. Quality in CLO-led spaces must be safeguarded through structured training, mentorship and supervision. Competency frameworks can be used to set minimum training hours, observed practices and periodic re-certification. Supervision can be

documented through case reviews, debriefs and reflective practices, and well-being measures can help prevent burnout. Formal certification of community work and peer education can further strengthen quality assurance by standardizing skills, recognizing the professionalism of peer roles and ensuring that peer educators can also access protections such as employment recognition and retirement benefits. In parallel, formal job descriptions, salary scales and progression pathways replace reliance on unpaid volunteerism, which communities identify as incompatible with continuity and quality.

129. Community-led providers become legitimate and valued partners within national health systems when they can obtain accreditation or certification; are contracted or reimbursed for defined services; and are included in national plans and benefit packages. Accreditation can be used to set quality and safety expectations.

130. Recognition also implies visibility in national coordination, inclusion in referral directories and digital platforms, eligibility to contribute to national guidelines, and participation in performance reviews. Formal recognition validates the professionalism of community-led providers, reinforcing their credibility and equal standing alongside other health system actors.

131. Institutionalizing the community workforce within government structures is essential, enabling peer and lay providers to be formally recognized and resourced and allowing for the data they collect to be legitimized in national systems. This requires policy reforms that go beyond business-as-usual and support decolonized integration of community providers as equal partners in the health system. Where regulations limit which cadres may deliver which services, policy updates enable certified peer and lay roles within appropriate supervision, ensuring that what communities already do safely can be sustained and counted.

132. Depending on the service delivery model preferred by CLOs, hiring trained health-care workers, nurses and doctors may be an important strategy for providing comprehensive services, so that clients do not have to attend other clinics or hospitals. However, it is essential that these cadres receive significant, recurrent and community-led training to ensure cultural competence for serving key populations and other marginalized groups.

133. Ensuring the safety of patient populations is paramount. Integration, whether incorporating additional services into community-led spaces or expanding community-led care in public clinics, must include structural changes to address stigma and discrimination, must fund advocacy for community priorities, must include facility-level investments in safety and security, and must include systems for tracking and addressing violations of client safety and confidentiality.

134. Integrated, community-led service delivery will not replace the care some clients require from specialized providers, secondary and tertiary care facilities, and other specialized centres. Initiatives to strengthen integration therefore must explicitly include investments in stronger coordination and referral capacities. That can include making transfer procedures accessible and fair; providing financial support with transportation; and making medical record systems interoperable, confidential and acceptable to clients.

> *"Community-led in my context,* [means] *it should be led by the communities, including all the staff. Why? Because they are familiar with where the communities mostly exist. The community-led response is usually less stigmatized and discriminated against… So, when you do outreach for service delivery, they know where to go, and they know how to engage with that and how to connect with them."*
>
> - Community expert from Asia-Pacific

Integrated service delivery must conserve community leadership, ownership and safe spaces

135. Community-led service delivery exists as a direct response to the failure of public health-care systems to effectively provide accessible, safe and welcoming spaces for all patient populations.

136. The first priority for expanded community-led, integrated HIV services is to protect pathways for clients to continue receiving the health-care services they need. Safety and dignity must be treated as non-negotiable quality standards.

137. Rights-affirming practices can be implemented through staff codes of conduct, anti-discrimination policies and regular training on stigma, discrimination and gender-based violence. Physical spaces should be designed to be welcoming and discreet, such as "neutrally signposted" entrances and private waiting areas. For criminalized populations, practical protections such as zero-disclosure dispensing, anonymous testing options, and immediate access to legal advice are important. It should be easy for people to lodge complaints. Investigations into complaints should be prompt and, where require, trigger corrective actions.

> "[Community-led services] *is where there is no judgment, no fear of stigma and discrimination* [and] *safe to share my problem. If I belong to community […] someone is there to listen to my story. For example, if I'm in pain, I'm open to share, I mean, I'm comfortable to share, someone to mentor or counsel me. If I'm in trouble, especially, I feel safe to share all my problems without hesitation."*
>
> - Community member, Asia-Pacific

138. Confidentiality is a core consideration when delivering services to both people living with HIV and key populations, particularly in contexts where disclosing clients' HIV status, gender identity, sexual orientation, drug use, or where participation in sex work creates risk of imprisonment, violence, stigmatization, discrimination, harassment and ostracization. Confidentiality-by-design must be built into appointment systems, for example through discreet booking, reception processes, dispensing and record-keeping. Data handling needs to follow strict "minimum necessary" rules, with clear consent processes. No client data should be shared with third parties, including law enforcement, without due legal process and safeguards.

139. The HIV response has developed specific methods to increase access to care while protecting client anonymity. When integrating other forms of care into HIV spaces, preserving lower threshold access to care is essential. A variety of differentiated, facility-based models for HIV treatment have been proposed, which include delivering

care through clinician- and/or client-led patient groups, as well as by streamlining facility-based medication pick-up.[lxxv]

140. Special care is needed if community-led services are integrated into public clinics, particularly if these spaces collect detailed demographic information, biometric identifiers, or data on key population status. Communities must be involved in decision-making about the uses and governance of clinical data.

141. Efforts to integrate community-led services into general clinics or hospitals must be extremely sensitive to confidentiality risks and must take care to design patient spaces (for example, waiting rooms, pharmacies and examination rooms) to not expose medical or personal information. Signage, separate queues, designated waiting rooms, audible disclosure of appointment purpose, packaging of medication and health products, and other considerations must be carefully considered in close collaboration with communities.

> *"[Key populations-led clinics] do things that other clinics don't think about. For instance, having an escape route if they get attacked; having alternative means of entering and exiting the building. These are all things that are vital and integral to key population-led services, because we're criminalized in many places. And I don't think most standard government-run or hospital-run or charity-run clinics think about things like that."*
>
> - Community expert

142. For Indigenous communities, integration with mainstream health systems must not replicate colonial patterns of forced assimilation.[lxxvi] Respondents described formalizing governance commitments through ceremony rather than policy alone, recognizing that Indigenous protocols must take precedence over Western bureaucratic mechanisms. Where non-Indigenous organizations serve Indigenous communities, they must work in formal partnership with Indigenous-led organizations and transfer leadership and resources according to Indigenous direction.

143. In addition to providing services, CLOs often play skey role in actively advocating for community priorities, gathering feedback about patient needs, and serving as allies to marginalized and disenfranchised populations. Expanding the technical capacities of these organizations to provide broader services must preserve community leadership. For instance, if CLOs hire clinicians, care must be taken to ensure that technical staff do not take leadership positions in the organization. If CLOs choose to offer community-led services in public health-care systems, this must be accompanied by governance structures and management frameworks that protect the ownership of the CLOs in mapping community priorities, developing strategies for delivering care, and acting as independent advocates.

> *"One of the things that needs to be considered via social contracting are ways to ensure that the contracts are not individualized so that individual people are hired and lack community. You have a lay health worker who happens to be living with HIV. She's hired along with five other women to do "X" in this community, go door-to-door, talk to these people, do adherence counselling, breastfeeding. And then, you find out that one woman has spoken up, and suddenly she's not a lay health worker anymore. And there's no infrastructure there to support her, to raise those kinds of issues. Because we still don't have very good processes for accountability."*
>
> - Community expert, North America

144. Offering a broader range of services can risk eroding highly specialized, population-specific care. For instance, offering more general "wrap-around" health care may attract clients from outside the CLO's target population. Serving a more diverse patient population can help destigmatize service delivery. However, catering toward a more general population risks replicating the same barriers that exist in primary health care (e.g. stigmatization and reduced capacity to provide specialized care) and displace trusted providers.

Community-led service delivery depends fundamentally on an enabling legal and policy environment

145. Consistent with the Global AIDS Strategy and the 10–10–10 societal enablers, this report addresses legal and policy conditions—alongside service design—because enabling environments and community-led, integrated delivery are mutually reinforcing prerequisites for reducing HIV risk and sustaining care among people living with HIV, key and priority populations, women and youth.

> *"We need the voice of UNAIDS. Our government listens to UNAIDS staff and [...] UNAIDS provides safety for key populations in different countries, provides a platform for conversations to happen within government and for key populations to provide leadership [...] If UNAIDS is not there, it gives the sense that AIDS is done, and we can all move on."*
>
> - Community expert, North America

146. The feasibility of expanding community-led, integrated health-care delivery is shaped by national contexts. Similarly, the ability to expand the scope, reach and mandate of CLOs depends on laws and government policies. These can include criminalizing laws, regulations pertaining to service provision, accreditation, supply chains, data sharing and quality assurance mechanisms.

147. Virtually every country in the world has criminalized at least one key population,[lxxvii] even though decriminalization has been shown to reduce exposure to violence and discrimination, lower barriers to care and enable harm-reduction and other prevention and treatment services to operate effectively and lawfully.[lxxviii] [lxxix] [lxxx] [lxxxi] In addition, the expansion of community-led and integrated HIV responses is being challenged by other restrictive laws, the anti-gender backlash, shrinking civic space and systemic discrimination against key populations. A top priority is to create environments that safeguard CLOs from legal exposure and that protect the autonomy of community

leaderships.

> *"It's just not possible to integrate key population services entirely into government health-care settings without also decriminalizing laws that criminalize key populations."*
>
> - Community expert, North America

148. One major hurdle to the expansion and sustainability of community-led service delivery is the limited embrace of government contracting to civil society and community organizations, also known as social contracting. Partnerships between government and nongovernmental entities to meet the health needs of communities are relatively common in some countries, but difficult to achieve in others.

149. Support for community-led advocacy is a prerequisite for expanding integrated care. This must include support to engage in accountability and oversight spaces, including and Global Fund country coordinating mechanisms (CCMs). Care must be taken in contexts transitioning from donor support into the national system. The experiences of post-transition countries indicate that donor-supported accountability spaces, such as CCMs, typically do not persist. Functioning, funded and participatory spaces for advocacy (e.g. human rights councils, national AIDS councils and civil society fora) should be developed before donor support ends.

Case study: Women's leadership in Latin America and Caribbean (ICW Latina)

The International Community of Women Living with HIV (ICW) addresses the complex challenges faced by women living with HIV across regions, with a particular focus on marginalized and priority populations. Operating in diverse contexts from Latin America to Africa, ICW has developed a comprehensive approach to supporting women living with HIV, through recognizing the intersectional challenges of gender, health and social justice. The organization serves women from diverse backgrounds—including lesbian women, women who use drugs, migrant sex workers and racialized individuals—with a commitment to providing holistic support that goes beyond medical intervention.

ICW works along multiple strategic pathways. It established a network of community-led services that provide integrated support spanning medical care, psychological assistance and legal support services. It also developed peer support mechanisms, training programmes and advocacy initiatives that empower women to navigate the complex challenges of living with HIV.

The organization focuses on several key intervention strategies. Firstly, ICW Latina supports community-led services, with the aim of enhancing treatment adherence and overall well-being by developing support systems directly managed by women living with HIV. Secondly, it conducts research and advocacy to combat discrimination and increase awareness about HIV, particularly within health-care systems. Thirdly, ICW Latina provides holistic services that address medical, psychological and legal needs of women living with HIV. Finally, the organization conducts rights advocacy and works to improve legal protections and access to resources for women living with HIV, including challenging discriminatory policies.

In some countries, ICW Latina has successfully advocated for legal changes, including pension

rights and early retirement provisions for individuals diagnosed with HIV, as well as advocated for more accurate information about breastfeeding for women living with HIV. The programme has been particularly effective in addressing reproductive rights, challenging existing health-care policies that marginalize women living with HIV. Research conducted by ICW Latina in countries like Bolivia, Nicaragua, Honduras and Peru has been crucial for understanding and addressing the specific challenges faced by women living with HIV. The organization's training programmes on sexual and reproductive rights have also been instrumental in empowering women and linking their experiences to broader feminist movements in Latin America and the Caribbean.

What do we need to do differently?

150. Based on a global consultation process, survey and literature review, the following recommendations are proposed.

151. **Adopt an integrated package of services**

- This report calls on Member States, with the support of the Joint Programme, to ensure the availability and accessibility of a defined package of integrated services. National HIV plans should explicitly link HIV testing, prevention (including long-acting options, where authorized), and treatment with the broader set of services that communities consistently identify as essential.
- National HIV plans should include trans-specific health care, harm reduction, comprehensive sexuality education, sexual and reproductive health and rights, mental health care and psychosocial support, counselling and peer accompaniment, as well as basic social support such as food programmes and housing.
- This package should be delivered through community-led services–-including clinical and non-clinical settings such as community centres, community-led clinics, mobile stations and outreach spaces—with CLOs recognized and resourced as essential providers.

152. **Finance the future of community-led integration**

- New models for funding community-led organizations for service delivery should be defined and promoted, shifting away from donor pathways that channel resources strictly through governments. Funding to community-led organizations for service delivery should include indirect costs and overheads; should support the professionalization and remuneration of staff with proper employment contracts and benefits; and should include resources for sustainable resource mobilization
- All initiatives to support integrated health-care services must include dedicated funding to CLOs, as well as a commitment to preserve community-led service delivery in safe spaces for key populations, and to prioritize the delivery of supportive and "wraparound" care. In many contexts, integration should expand the scope of CLO service delivery, as a counterpoint to efforts to transition community-based care into the public health-care system

- Functional social contracting pathways must be proactively developed well before donors remove or transition their support, to ensure that domestic funding reaches CLOs for their service delivery activities.
- In all contexts where the public health-care system perpetuates barriers to service delivery (including criminalization, stigmatizing attitudes, refusal of care, damaging gender norms and violations of client confidentiality), donors must continue to support earmarked resources to support CLO-delivered services for key populations.
- The global community is urged to address the evolving challenges in the global health funding landscape and the growing financial pressures in the HIV response by committing to long-term, sustainable investments, including through a strong Global Fund replenishment, robust bilateral support for HIV programmes and continued support for key partners.
- A continuity-of-functions plan for 2027–2030 should be presented to by the 58th meeting of the PCB, with the Joint Programme mapping essential HIV-response functions (including community-led integrated services, community-led monitoring, and human rights and legal environment work), and convening/coordination, against responsible entities, indicative budgets, scenario triggers, and contingency actions, with annual public reporting.
- The continuity of core HIV-response functions must be safeguarded during the current financial crisis, with Member States and donors ensuring that rights-based and community-led services are not interrupted.

153. **Build community capacity to deliver community-led, integrated services**

- Donor funding streams must prioritize empowering CLOs to deliver a broader set of HIV and non-HIV-related services through sustained training, capacity building and support. This should include facilitation to hire technical staff, adequately compensate community staff and professionalize their human resources infrastructure. Additionally, it is essential that CLOs are supported to develop resource mobilization and financial management skills, to reduce reliance on donor funding, generate income and manage resources for non-HIV service delivery.
- Funding for training must be provided, including technical training to strengthen the capacity of community health-care workers and CLO staff to deliver a broader set of services, as well as community-led training on cultural competency and quality HIV care for public health-care clinical staff.
- Resources for advocacy must be included in donor funding streams and must include support for community-led monitoring and participation in accountability spaces. CLOs play a fundamental role in tracking and responding to human rights violations.
- Support for community-led, integrated service delivery should include efforts that make transfer procedures accessible and fair, financial support for transportation, proactive and community-based retention and adherence support, and medical record systems that are interoperable, confidential and acceptable to clients.

154. **Conserve community leadership, ownership, and safe spaces**

- Decisions about integrated service delivery must ensure that the expertise and leadership of communities of people living with and affected by HIV are consistently valued in all aspects of decision-making, planning, strategy and implementation
- Spaces for meaningful dialogue and co-ownership of community-focused programmes must be strengthened and created, including for the development of national strategic plans, the Global Fund's CCMs and national AIDS councils. The creation and reinforcement of accountability platforms well before donor withdrawal is needed to protect the gains of the HIV response.
- There must be strong commitment to the meaningful involvement of communities in the development of the next Global AIDS Strategy and the 2030 targets and to ensuring that civil society and community priorities are represented at the 2026 High-Level Meeting on HIV and AIDS and in the language of the next Political Declaration on HIV.
- The 30–80–60 targets must be retained and reinforced by developing an operational monitoring and accountability framework that is linked to a prioritized, accelerated action agenda. In support, a clear narrative that links the 30–80–60 targets for community-led interventions to the 95–95–95 targets for treatment access and adherence and to the 10–10–10 societal enabler global targets (as well as other relevant targets agreed to in the Political Declaration) must be developed to highlight the centrality of community leadership in achieving all global targets.

155. **Create enabling environments and policy frameworks**

- As national governments anticipate taking on a greater share of the financial responsibility for funding HIV services, laws restricting sub-contracting to CLOs must be revisited and revised. Social contracting is essential for formalizing government and community partnerships and creating strategic interdependencies.
- More must be done to expand opportunities for and remove barriers to community-led organizations to gain and retain formal registration. Formal registration processes are often lengthy, cumbersome, confusing and costly. Formal registration is often impossible or dangerous for key population-led organizations in countries where those populations are either explicitly criminalized or heavily discriminated against. According to Outright International, in 2023 LGBTIQ organizations could operate legally in only 94 countries.[lxxxii] Such concerns about the ability of CLOs to gain and retain formal registration were shared by participants from the Global North and Global South alike.
- Decriminalization must be pursued as a fundamental prerequisite for integration between CLO-led service delivery and government health systems. Global partners must commit to urgently and expeditiously removing legal, policy and human rights barriers to communities, including people living with HIV, at risk of, or affected by HIV.
- The UNAIDS Secretariat and Cosponsors must collaborate closely with national AIDS councils and commissions, and other key national government stakeholders, to anticipate and prepare for anti-rights, anti-gender and anti-civil society

mobilization, and to prevent the adoption of new restrictive measures that could undermine community-led services delivery.

- Gender-transformative approaches and self-care should be mainstreamed within policies governing HIV service delivery to ensure that marginalized communities are fully supported and empowered.
- Member States and partners must support and recommit to the Global Partnership to eliminate all forms of HIV-related stigma and discrimination as a platform for partnership, collaboration, exchange and mentorship between countries to advance human rights and gender equality and resilient community-led responses.
- Linkages between the Global Partnership and key institutions, in particular the Office of the High Commissioner on Human Rights, must be strengthened.
- Scope-of-practice reforms should be advanced so that community-led providers can legally deliver agreed services, including testing, harm reduction, ART delivery and legal aid and referrals.
- Early warning and rapid response mechanisms must be established to detect restrictive laws and practices, and they should link community monitoring to rapid legal policy responses and protection protocols for CLOs and defenders.

156. **Strengthen the legitimacy of community leadership and responses for alignment to national health systems**

- Countries must work to revise regulations restricting the range of services CLOs that are legally allowed to provide. As of 2025, CLOs were allowed to conduct HIV testing and distribute antiretrovirals in 84 and 39 countries, respectively. They could distribute condoms in 92 countries, provide naloxone in 15 countries, and provide legal services in 55 countries.[lxxxiii] Countries should also eliminate restrictions that limit the ability of CLOs to provide non-HIV services.
- Community-led models must be embedded within government frameworks to increase the likelihood of domestic financing, facilitate social contracting and help transcend the current fragmentation of service delivery.
- Community-led organizations must be formally recognized as part of the health system architecture and must be reflected in national strategic plans, investment cases and HIV integration strategies.
- CLO service delivery models must be mapped and linked to existing government plans to ensure their inclusion in domestic financing and accountability frameworks.
- Joint planning platforms must be established between governments and CLOs to align priorities, while safeguarding the independence, innovation and rights-based focus of community-led responses.

157. **Embed community-led monitoring, implementation and accountability in alignment with national health systems**

- The accountability of all actors engaged in the delivery of services must be strengthened to improve service delivery, responsiveness and impact. Community-led monitoring, in which community organizations independently

gather data and advocate for improvements in health care delivery, is the principal mechanism through which accountability is realized at service level.

- While national governments are often the primary focus of accountability efforts, global and regional actors—including UN agencies, bilateral donors, and implementing partners—must also be held accountable for their commitments to community leadership, equity and integrated service provision.
- Community-led monitoring must be resourced to produce routine, disaggregated data on service quality, rights and enablers, with feedback-to-action mechanisms embedded in national HIV plans and provider contracts.
- A financing taxonomy that tracks public and donor flows to CLOs (including for community-led monitoring and legal support), as well as progress on legal and policy reforms, social contracting and civic space protections must be included in accountability efforts.

Case study: Apoyo Positivo—Community-led integrated HIV, sexual health and harm reduction services in Spain

Apoyo Positivo is one of Spain's leading community-led providers of integrated HIV, sexual health and harm reduction services. It offers HIV and STI testing, psychosocial care, harm reduction for people who use drugs, gender-affirming services, housing support and legal assistance. Services are delivered by community members, including people living with HIV, gay men and other men who have sex with men, transgender people, migrants, people who use drugs and peers from affected communities.

HIV and sexually transmitted infection testing are the main entry points, after which each person receives a personalized, community-led and integrated care plan. Staff and clients identify needs across sexual health, mental health, drug use and social support, and co-design an integrated package that may include psychosocial counselling, sexuality-focused support, peer accompaniment or linkage to HIV units, addiction services or gender-affirming providers.

Apoyo Positivo also delivers one of Europe's strongest community-led chemsex and harm reduction programmes, which is co-designed and provided by peers, including people who use drugs. The programme offers safer-use counselling, screening for problematic use, individual psychosocial support and structured harm reduction plans. Peer-led groups provide guidance on safer practices, crisis management, consent and sexual health, with seamless referral into HIV and sexually transmitted infection testing, mental health care and social services.

Partnerships with the public health system reinforce the model. Hospitals refer clients for psychosocial support, sexually transmitted infection testing and housing assistance, while Apoyo Positivo trains around 300 clinicians annually in cultural competence, chemsex and community-led care. It was the first community organization included in Spain's national sexually transmitted infection guidelines.

In addition to its clinical services, Apoyo Positivo operates a community residence for people living with HIV and for gay men and other men who have sex with men, transgender people and other people experiencing homelessness or distress. The organization also supports around 300 migrants with HIV each year to enter the health system and initiate treatment.

Apoyo Positivo shows how community-led providers deliver fully integrated services that reach communities which public systems struggle to serve, improving outcomes for gay men and other men who have sex with men, transgender people, migrants and people who use drugs.

Case study: LGBTI leadership in Africa (GALZ)

For over three decades, GALZ, an association of LGBTI people in Zimbabwe, has provided safe spaces and essential services in a highly hostile legal environment, where same-sex relations are criminalized and public officials have called for restrictions on foreign funding. GALZ has also documented systemic barriers to care through its Sexual and Reproductive Health and Rights Access Survey, which found that 26% of LGBTI people experienced confidentiality breaches and 45% were denied services or subjected to intrusive questioning.[lxxxiv]

At the centre of GALZ's work is a community-led service model that integrates psychosocial support, legal assistance and HIV services. The organization operates four community-run drop-in centres that offer counselling, legal advice and safe-space support. Mental health is a major entry point into care: in 2024, over 21 000 people accessed confidential psychosocial support via TakaTaka, a chat-based service described by users as being "like talking to a friend".[lxxxv]

Legal and rights services are another branch of work. Paralegals and community advocates provide immediate legal support for cases such as blackmail, police harassment and assault. Partnerships with organizations like the Zimbabwe Lawyers for Human Rights ensure access to representation. In 2024 GALZ's advocacy helped secure Zimbabwe Human Rights Commission intervention to support intersex children in obtaining birth certificates.

GALZ's network of drop-in centres, peer supporters and affinity groups extends services into peri-urban and rural communities and ensures ongoing feedback on safety, health and legal needs. GALZ's approach is also highly integrated. Government health workers provide HIV testing, PrEP and ART from GALZ centres twice a week, with GALZ ensuring that care is delivered in a safe and affirming environment. In 2024, 670 gay men and other men who have sex with men tested for HIV at the Harare centre, 188 started PrEP and 41 initiated ART, with 100% retention among those aged 20–24 years.

The organization also strengthens public-sector responsiveness by training health workers and placing LGBTI representatives on health centre committees, ensuring that public structures remain safe, accountable and accessible.[lxxxvi]

Conclusions

158. This report is presented at a time of immense upheaval in the HIV response and a financing crisis that is creating an existential threat to many community organizations and to the Joint Programme.

159. As donor funding diminishes, the global HIV response is actively pursuing increased domestic resources for HIV, as well as greater integration and ownership of donor-supported programmes by governments. In the context of persistent and widespread

criminalization and a growing anti-gender and anti-rights movement, the global targets of the 2021–2026 Global AIDS Strategy are increasingly at risk of not being met. The current context threatens the progress made by the HIV response to protect the rights and well-being of people living with HIV, key populations and communities affected by the pandemic.

160. As shown in this report, communities have been clear and consistent in identifying the services that must accompany HIV testing, prevention (including long-acting technologies) and treatment. This integrated package includes:

- mental health care and psychosocial support, including counselling and trauma-informed services;
- peer accompaniment and navigation, ensuring people are supported across care pathways;
- basic social support, such as food and housing assistance;
- legal assistance and protection from violence and discrimination, including access to paralegal support, gender-based violence response, and safe reporting mechanisms;
- trans-specific healthcare, including gender-affirming services;
- harm reduction, including sterile injecting equipment, naloxone, overdose response and safer-use education; and
- comprehensive sexuality education for adolescents and young people, sexual and reproductive health and rights, including contraception, pregnancy and breast-feeding care.

161. These services are not optional add-ons, but essential conditions for enabling people to start and stay in care, maintain viral suppression, and halt onward transmission of HIV. Delivered through both community-led and mainstream settings—including non-clinical spaces such as community centres and mobile stations—this comprehensive package reflects what communities know is required to achieve equity, dignity and effectiveness in the HIV response.

162. The path forward requires a deliberate commitment to preserve and scale community-led, integrated services as a permanent feature of national health systems. Integration must not be used as a pretext to dismantle community infrastructure or roll back rights. Governments, donors and United Nations partners must act with urgency to ensure that community-led organizations are resourced, legally enabled and institutionally recognized as indispensable partners in delivering sustainable, people-centred and rights-based HIV responses.

Proposed decision points

163. *Take note* of the report by the NGO representative;

164. *Recognize* the indispensable role of communities as service providers, caregivers, advocates, monitors, and leaders, and recognizes that meaningful community leadership and well-resourced community-led HIV responses are fundamental to the

realization of the Global AIDS Strategy, to the attainment of the 30–80–60 and 10–10–10 targets, and to ending AIDS as a public health threat;

165. *Recall* all decision points from agenda item 1.4 of the 55th PCB;

166. Noting with concern that reaching the goal of ending AIDS as a public health threat by 2030 is being negatively impacted by declining and unpredictable funding for community-led HIV responses, restrictions on civic space, regressions in gender equality and human rights as recognized under international human-rights law, and persistent stigma and discrimination, and other emerging challenges, *calls upon* Member States:

    a. Ensure that predictable, sustainable, and direct financing is directed to community-led organizations engaged in the HIV response, including through institutionalized social contracting and dedicated domestic budget lines, and ensure the full, timely, and increased funding mechanisms dedicated to community leadership and resilience, including within UNAIDS;

    b. Address structural, legal, and policy barriers to support equitable and human-right based, community-led integrated HIV services that leave no one behind including people living with and affected by HIV, particularly key[1] and priority populations, guided by community leadership and societal enablers to end HIV-related stigma, discrimination, and gender inequalities and health inequities;

    c. Develop, with the support of the Joint Programme, comprehensive and integrated health and social support service packages known to reduce HIV risk and vulnerabilities within national HIV and health plans, that link HIV testing, prevention including long-acting technologies, and treatment to the tailored needs of people living with and affected by HIV, particularly key and priority populations;

    d. Integrate and strengthen peer-led service delivery and community-led monitoring to improve service delivery quality, strengthen health systems, and enhance health equity including while encouraging innovative and digital approaches for monitoring and evidence-based decision-making in the national HIV response and broader health sector;

    e. Ensure that people living with and affected by HIV, particularly key and priority populations are actively engaged in the process of integration of the HIV response into related, coordinated multi-sectoral programmes;

    f. Strengthen systematic reporting through annual update of Global AIDS Monitoring report, in a transparent and disaggregated manner, on donor and domestic budget allocations supporting community-led responses and Human Rights programming, to monitor and inform progress toward the 30–80–60 and 10-10-10 targets, working collaboratively with Co-sponsors and the UNAIDS Secretariat;

167. *Request* the Joint Programme to:

a. Develop a plan through 2030 for the continuity of the support to and engagement of communities currently delivered by the UNAIDS Secretariat in the context of the further integration of UNAIDS into the broader UN system;

b. Reaffirm commitment to the meaningful involvement of people living with and affected by HIV, particularly key and priority populations in the implementation of the Global AIDS Strategy 2026–2031 and the UN General Assembly 2026 High Level Meeting on HIV/AIDS;

[Annexes follow]

Annex 1. Glossary

Term	Definition
Adolescent girls and young women	Girls and young women aged 15–24 years. They face heightened HIV vulnerability due to gender inequality, violence and barriers to sexual and reproductive health services.
Adolescents and young people	People aged 10–24 years. Their HIV risk and service access are shaped by rapid developmental transitions and limited access to age-appropriate information, prevention and care.
Chemsex	Intentional use of specific psychoactive substances to initiate, enhance or prolong sexual activity, most commonly among gay and other men who have sex with men and by transgender women. It is associated with increased risk of acquiring and transmitting HIV and other STIs.
Community-led	Responses or programmes planned, delivered and monitored by community-led organizations in which community members hold primary leadership and decision-making power.
Community-led AIDS responses	Actions and strategies that seek to improve the health and human rights of constituencies and are specifically informed and implemented by and for communities themselves and the organizations, groups and networks that represent them.
Community-led integrated HIV services	HIV prevention, testing, treatment, care and support designed and delivered by community-led organizations and linked with broader health and social services so that people receive holistic, people-centred care in a coherent continuum.
Community-led monitoring	A community-based accountability mechanism where community-led organizations routinely collect, analyse and use data on service quality, access and acceptability and engage duty-bearers to improve services.
Community-led organization	Organizations in which most governance, leadership, staff, spokespeople and volunteers reflect the constituencies served, and which are self-determining, autonomous and accountable to those communities.
Comprehensive sexuality education	A curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality that is scientifically accurate, age-appropriate, culturally relevant and rights-based.
Gay men and other men who have sex with men	Men who engage in consensual sexual activity with other men, regardless of how they identify, recognized as a key population with elevated HIV risk.
Trans-specific health care	A range of social, psychological and medical interventions that support transgender and gender-diverse people to live in ways that affirm their gender identity, including gender-affirming hormone therapy and, where chosen, surgeries.
Gender-based violence (gender-based violence)	Harmful acts directed at a person based on gender, including physical, sexual, psychological and economic violence, which increase vulnerability to HIV and create barriers to accessing services.

Harm reduction	Policies, programmes and practices that aim to reduce the negative health, social and economic consequences of drug use without necessarily requiring abstinence, including needle and syringe programmes, opioid agonist therapy and overdose prevention.
HIV-related criminalization	Use of criminal law to regulate HIV non-disclosure, exposure or transmission, often in ways that are not aligned with science or human rights and that can undermine HIV prevention, testing and treatment efforts.
Indigenous peoples and racial, ethnic and religious minorities	Communities that experience discrimination, marginalization and exclusion which heighten their HIV vulnerability and limit their access to services. They are recognized in the Global AIDS Strategy as populations facing intersecting inequalities.
Integrated health services	Management and delivery of health services so that people receive a coordinated continuum of promotion, prevention, diagnosis, treatment, care and rehabilitation across different levels and sites of care.
Key population-led organizations	Community-led organizations in which the majority of leadership, governance, staff and members are people from key population groups themselves.
Key populations	Groups at increased risk of HIV and facing greater barriers to services, specifically sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs and people in prisons and other closed settings.
Mental health and psychosocial support	Preventive and clinical mental health interventions and social and psychological support that address conditions such as depression, anxiety and substance use which affect well-being and HIV outcomes.
Migrants, refugees and people in humanitarian settings	People whose mobility, legal status, displacement or exposure to crises increases HIV vulnerability and restricts access to health, protection and social services.
People in prisons and other closed settings	People held in prisons, jails, detention centres or other closed settings, who face elevated risks of HIV, tuberculosis and viral hepatitis and often have limited access to comprehensive prevention, treatment and harm reduction services.
People living with HIV	Children, adolescents and adults who have acquired HIV infection.
People who inject drugs	People who inject psychoactive substances, such as opioids or stimulants; they are recognized as a key population with high risk of HIV and viral hepatitis.
People who use drugs	People who use psychoactive substances by any route (injecting or non-injecting), whose HIV and health risks are shaped by drug type, patterns of use and structural factors such as criminalization, policing and stigma.
People-centred care	An approach to health service design and delivery that is organized around the needs, preferences and circumstances of people, their families and communities, treating them as partners in care.
People with disabilities	Children, adolescents and adults who have long-term physical, mental, intellectual or sensory impairments which, in interaction with barriers, may hinder full and effective participation in society and are associated with heightened vulnerability to HIV and barriers to services.

Priority populations	Groups who, due to social, economic, legal or geographic inequalities, are more exposed to HIV risk or have reduced access to services. They include adolescent girls and young women, migrants, youth, people with disabilities and some racial or ethnic minorities.
Sex workers	Adults who receive money or goods in exchange for sexual services, either regularly or occasionally, and who often face criminalization, violence and stigma, which heightens HIV risk.
Sexual and reproductive health and rights	The right of all people to make informed decisions about their sexuality and reproduction and to access the information and services needed to realize those rights, including contraception, safe pregnancy and childbirth, and freedom from violence and coercion.
Social enablers	Laws, policies, rights-based programmes and community mobilization efforts that create an enabling environment for effective, equitable HIV responses and service uptake.
Social protection	Policies and programmes that reduce poverty and vulnerability and support people to cope with shocks, such as cash transfers, social insurance, labour market policies and social care, which can reduce HIV risk and improve treatment adherence and outcomes.
Trans and gender-diverse people	People whose gender identity differs from the sex assigned at birth, including transgender women, transgender men and non-binary people, who in many settings experience heightened HIV vulnerability due to stigma, discrimination and violence.
Women-led organizations	Community-led organizations in which most governance, leadership and members are women and girls from the constituencies served, playing a critical role in advancing gender equality, gender-based violence prevention and response and women's SRHR in the HIV response.
Young key populations	Adolescents and young people (10–24 years) who are also members of key population groups. They include young sex workers, young and other gay men who have sex with men, young transgender people and young people who inject or use drugs, all of whom face compounded vulnerabilities and barriers to services.
Youth-led organizations	Community-led organizations in which most governance, leadership and members are adolescents and young people, and which are recognized as a specific category of community-led responses in the HIV response.

Annex 2. Survey demographics

Respondent characteristic	n (%)
Overall number of Respondents	**151**
HIV services user	
Yes	113 (75%)
No	28 (19%)
Prefer not to respond	10 (7%)
HIV services provider	
Yes	60 (40%)
No	87 (58%)
Prefer not to respond	4 (3%)
Funder	
Yes	14 (9%)
No	131 (87%)
Prefer not to respond	6 (4%)
Gender	
Cisgender woman	47 (31%)
Cisgender man	62 (41%)
Trans woman	12 (8%)
Trans man	4 (3%)
Non-binary or gender fluid	13 (9%)
Prefer not to respond	13 (9%)
Age (years)	
Under 18	3 (2%)
18 to 24	9 (6%)
25 to 34	47 (31%)
35 to 44	39 (26%)
45 to 54	23 (15%)
55 to 64	21 (14%)
65 years and over	7 (5%)
Prefer not to respond	2 (1%)
Key or priority population	
Gay and other men who have sex with men	60 (40%)
Adolescent girls and young women	27 (18%)
Transgender people	9 (6%)
Sex workers	8 (5%)
People who use drugs	4 (3%)
Adolescent boys and young men	3 (2%)
Migrants refugees and asylum seekers	2 (1%)
Other	13 (9%)
Not a member of a key population	25 (17%)
Prefer not to respond	8 (5%)
Region	
Caribbean	1 (<1%)
Central Africa	8 (5%)
Central America	4 (3%)
Central Asia	2 (1%)

Eastern Africa	39 (26%)
Eastern Asia	1 (<1%)
Eastern Europe	3 (2%)
North America	11 (7%)
Northern Europe	12 (8%)
South America	18 (12%)
South-Eastern Asia	15 (10%)
Southern Africa	4 (3%)
Southern Asia	1 (<1%)
Southern Europe	3 (2%)
Western Africa	6 (4%)
Western Europe	21 (14%)
Prefer not to respond	2 (1%)

Annex 3. Key informant interviews

Key informant interviews	
Affirmative Action	Kevin Evina Ambah (West & Central Africa)
Alliance globale des communautés pour la santé et les droits (AGCS PLUS)	Jean Paul Enama Ossomba (West & Central Africa)
APCOM Foundation	Midnight Poonkasetwattana (Asia-Pacific)
Asia Pacific Network of People living with HIV/AIDS (APN+)	Harry Prabowo (Asia-Pacific)
Asia Pacific Network of Sex Worker (APNSW)	Fairy Abdulghani (Asia-Pacific)
Asia Pacific Network of Transgender (APTN)	Avali Khare (Asia-Pacific)
Global Fund Community, Rights and Gender (CRG) Learning Hub L	Anuar Luna (LAC)
Eastern Africa National Networks of AIDS and Health Service Organizations (EANNASO)	Rodrick W. Mugishagwe (East and Southern Africa)
East Africa Trans Health and Advocacy Network (EATHAN)	Barbra Wangari (East and Southern Africa)
European Network of People who Use Drugs (EuroNPUD)	Alexei Lakhov (Europe)
Global Action for Trans Equality (GATE)	Erika Castellanos (Global)
Global Black Gay Men Connect (GBGMC)	Micheal Ighodaro (Global)
Global Fund to Fight AIDS, Tuberculosis and Malaria	Keith Mienies (Global)
Global Network of People Living with HIV (GNP+)	Florence Anam (Global)
Harm Reduction Sisters	Sue Purchase (North America)
HIV Justice Network	Edwin Bernard (Global)
International Lesbian, Gay, Bisexual, Trans and Intersex Association Europe (ILGA-EU)	Cianan Russell (Europe)
International Network of People who Use Drugs (INPUD)	Aditia Taslim (Global)
International Community of Women Living with HIV (ICW)	Sophie Brion (Global)
International Community of Women Living with HIV Asia Pacific (ICWAP)	Sita Shahi (Asia-Pacific)
MPACT	Andrew Spieldenner (Global)

UHAI USA	Kent Klindera (North America)
Robert Carr Fund (RCF)	Felicia Wong (Global)
Sophia Forum	Sophie Strachan (Europe)
The Maroon Society	Michelle Enfield (North America)
TTCW+	Diana Weekes (LAC)
Viiv	Shaun Mellors (Global)
Women for Global Fund (W4GF)	Angela Caceres (LAC)
Global Network of Young People Living with HIV (Y+ Global)	Maximina Jokonya (Global)
Youth Leadership, Education, Advocacy, and Development Foundation (Youth LEAD)	Ikka Noviyanti (Asia-Pacific)

Case studies	
Nine Circles Community Health Center, Canada	Michael Payne
Tangerine Clinic, Thailand	Rena Janamnuaysook
Ready+, Africa (multi-country)	Cyprian Komba, Chengetai Dziwa, Lusungu Harawa
ICW Latina, Latin America and Caribbean (multi-country)	Mariana Iacono, Ana Ines Stravinskas
Gays and Lesbians of Zimbabwe (GALZ), Zimbabwe	Sylvester Nyamatendedza
Ayo Positivo, Spain	Jorge Garrido

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